UPDATES TO THE BOARD MEDICAL FEE SCHEDULE PUBLISHED SEPTEMBER 1, 2001

1. Make edits to third paragraph on page 6 as follows*:*

It is important to recognize that the listing of a code number, the service or procedure and the approved fee are not restricted to a specific specialty group. Any procedure or service and fee listed in this book may be used to designate the services rendered by any qualified physician. Such services, however, must be performed within the scope of his/her licensed practice as defined by Georgia law. **The Georgia State Board of Workers' Compensation fee schedule is the reimbursement guideline for Georgia facilities and providers; out of state facilities and providers are governed by usual, customary, and reasonable standards for reimbursements on Georgia claims and payment must be negotiated. Reimbursement for treatment rendered in Georgia for out of state claims will be governed by the regulations of the state having jurisdiction of those claims. (Revision effective June 1, 2002)**

2. Make edits to page 11 as follows*:*

Physician Extenders (PE)

The Clinical Nurse Specialist (CNS), Nurse Practitioner (NP), or Physician Assistant (PA) **as per O.C.G.A. 43-34-103(b),** if qualified by training and experience as determined by the supervising physician, may perform medical treatments, diagnostic procedures, or other delegated duties and tasks which are allowable by law, approved by the state licensing board, and which fall within the normal scope of practice of the supervising physician. **For scheduled visits, the Board requires a physician to provide evaluation and treatment in the course of the first visit. In situations of major/minor emergency, urgent care injuries, or other medical conditions requiring immediate attention, and where that care is provided in a medical facility staffed by physician extenders under the direction and supervision of a physician, services by the physician extender are covered for the initial treatment and visit. If follow-up treatment is necessary, the patient must then be referred to a physician for the follow-up visit, treatment and/or evaluation. Medical facilities covered include occupational medical centers, hospital emergency rooms, hospital-based clinics, hospital or physician federally approved rural health clinics, or federally qualified health centers. The federal tax id number for the supervising physician is to be used on claims for services rendered by physician extenders. Subsequent visits to a physician extender who is under the general supervision of the physician shall be paid in accordance with the Board fee schedule. (Revision effective June 1, 2002)**

3. Make edits to page 16 as follows:

> The peer review committees approved by the Board are listed below. These committees may be contacted at the following addresses and telephone numbers:

Dr. Mitchell S. Nudelman
Medical Director Solutions, L.L.C.
577 Seminole Drive
Marietta, GA 30060
(770) 499-0398 FAX (770) 499-8299

Dr. Eric Krohne, Executive Director
Georgia Chiropractic Association, Inc.
3772 Pleasantdale Road, Suite 175
Atlanta, GA 30340
(770) 723-1100

Ms. Pat Garner, Executive Director
Georgia Psychological Association
1750 Century Circle, Ste. 10
Atlanta, GA 30345
(404) 634-6272 FAX (404) 634-8230

Mr. Marvin Gross, M.S., P.T., Principal
Mr. Stuart Platt, M.S.P.T., P.T., Principal
Appropriate Utilization Group, LLC
1086 Burton Drive
Atlanta, GA 30329
(404) 728-1974

Ms. Ruth Brunder, President
Georgia Home Care Association
168 N. Johnson Street, Suite 304
Dallas, GA 30132
770-445-3180 ext 32 (Revision effective June 1, 2002)

4. Make edits to page 19 as follows:

Services provided pursuant to the Workers' Compensation Act are not confidential from the employer/insurer who, by law, are responsible for payment of medical services. The injured employee, upon request of the employer/insurer, shall furnish copies of all medical records and reports in his/her possession. The employer/insurer shall, upon the request of the injured employee, furnish copies of all medical reports in their possession. Upon failure of either party to furnish medical reports as provided above **and** when specifically requested by the employee, the physician or other medical provider shall furnish copies of all medical reports and bills in their possession at no expense to the injured employee or to his/her attorney. **(Revision effective June 1, 2002)**

Costs for these copies will be charged against the party responsible for payment of medical expenses. **Providers are entitled to collect reasonable charges for copies of medical records. In no event shall those charges exceed those charges provided for in O.C.G.A. §31-33-3.** Providers who use a medical records company to make and provide copies of medical records must ensure that neither the injured employee nor his/her attorney is billed for the cost of copies. **(Revision effective June 1, 2002)**

Special medical reports will be billed using CPT code 99080. X-ray copy charges will be billed at $9.50 per copy**.**

5. Make edits to page 23 as follows:

New & Established Patient

Except as provided herein, a new patient is one who has not received any professional services from a physician or another physician of the same specialty who belongs to the same group practice, within the past three years. **Each time an injured worker has a new compensable workers' compensation injury, the initial evaluation shall be coded as a new patient. (Revision effective June 1, 2002)**

6. Make edits to page 24 as follows:

Coordination of Care

When no patient encounter occurs, coordination of care by the authorized treating physician with other health care providers outside normal practice is reported and billed using case management codes (99361-99373). When a patient encounter occurs, any counseling and/or coordination of care with other health care providers as a part of or as a result of the encounter is considered part of the E/M code for that session. **Add the modifier -RS to the appropriate E/M code and reimbursement shall be at an additional 50% of the fee schedule MAR when the separate consultation with a Board registered rehabilitation supplier or case manager occurs**. **(Revision effective June 1, 2002)**

7. Add following modifier to page 31:

-RS **Rehabilitation Supplier: The rehabilitation supplier or case manager must be Board registered. In conformity with Board Rules 200.1 or 208, the purpose of the scheduled office visit must be to discuss the progress of the patient's treatment plan or an independent living plan on a workers' compensation injury. (Revision effective June 1, 2002)**

8. Make edits to page 37 as follows*:*

Time Reporting

Anesthesia time begins when the anesthesiologist begins to prepare the injured employee for the induction of anesthesia in the operating room, or in an equivalent area, and ends when the anesthesiologist is no longer in personal attendance (e.g., that is, when the injured employee may be safely placed under post operative supervision). The time value is computed by allowing one unit for each ten (10) minutes of anesthesia time during the duration of the service. In each instance, five minutes or greater is considered a significant portion of a time unit. For anesthesia lasting **a total** of less than five minutes, only base units without time units will be used to calculate reimbursement by the fee schedule. **If a medical provider bills for a portion of 10 minutes, round the time up to the next 10 minutes and reimburse one unit for the portion of time.** Acceptable time reporting requires that the hours and minutes of anesthesia be submitted. **(Revision effective June 1, 2002)**

9. Make edits to page 39 as follows:

- 47 **Anesthesia by Surgeon:** Anesthesia provided by the surgeon may be reported by adding the modifier (-47) to the basic service or by using the separate five digit modifier code 09947. This does not include local anesthesia. **Payment will be based on the lessor of the basic unit value without benefit for time or 25% of the total dollar value of the surgery.** Note: Modifier (-47) or 09947 would not be used as a modifier for the anesthesia procedures 00100-01999. **(Revision effective June 1, 2002)**

10. Make edits to page 41 as follows:

Miscellaneous

Local infiltration, digital block or topical anesthesia administered by the operating surgeon is included in the unit value for the surgical procedure.

If the attending surgeon administers anesthesia, the value shall be the lessor of the basic unit value without benefit for time or 25% of the total dollar value of the surgery. (See modifier –47). (Revision effective June 1, 2002)

11. Add the following ground rules to "General Guidelines" section on page 49:

- **When an endoscopic service is attempted and fails and another surgical service is necessary, only the successful service may be reported. For example, if a laparoscopic cholecystectomy is attempted and fails and an open cholecystectomy is performed, only the open cholecystectomy can be reported.**
- **An initial approach to a procedure may be followed at the same encounter by a second, usually more invasive approach. There may be separate CPT codes describing each service. The second procedure is usually performed because the initial approach was unsuccessful in accomplishing the medically necessary service; these procedures are considered "sequential procedures". Only the CPT code for one of the services, generally the more invasive service, should be reported. An example of this situation is a failed laparoscopic cholecystectomy,**

followed by an open cholecystectomy at the same session. Only the code for the successful procedure, in this case the open cholecystectomy, may be reported. This rule does not apply to planned multiple surgical procedures but they are subject to modifier -51 rule for multiple procedures. (Revision effective June 1, 2002)

12. Make following edit to first paragraph on page 53:

When 0 is listed in the FUD column, services provided the day of the procedure are included in the fee schedule amount. When 10 is listed in the FUD column, services provided the day of and during the 10 day period following the surgical procedure are included in the fee schedule amount. When 90 is listed in the FUD column, services provided the day of and during the **90** day period following the surgical procedure are included in the fee schedule amount.

13. Add the following modifier to page 59:

-57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery, may be identified by adding the modifier "-57" to the appropriate level of E/M service, or the separate five digit modifier 09957 may be used. (Revision effective June 1, 2002)

14. Make edit to CPT 99075 as follows: MAR

Medical testimony 1st hour or parts thereof/ each addit 15 Minutes $75.00 $300.

15. Make edits to page 233 as follows:

Add to end of the third paragraph "**See exception below**."

Add following paragraph after third paragraph:

When costs to the facility are increased, an additional surgical, out-patient payment is provided in the situation where an endoscopic/arthroscopic service is initially attempted by the surgeon and fails; and where a second usually more invasive procedure is required at the same encounter and to the same body part. This exception is due to the initial less invasive approach being unsuccessful in accomplishing the medically necessary service. Additional principal procedures meeting these criteria shall be paid at 75% of the difference between the amount specified in the ICD-9 Listing for the principal procedure in Field 80 and the total amount of the bill and documentation must be complete as set forth in previous paragraph. (Revision effective June 1, 2002)